## 2 Months Old — AHCCCS EPSDT Tracking Form

| Date | Last Name | First Name | AHCCCS ID # | DOB | Age |
|---|---|---|---|---|---|
| | | | | | |

| Primary Care Provider | PCP ph. # | Health Plan | Accompanied by (name) | Relationship |
|---|---|---|---|---|
| | | | | |

| NICU: ☐ yes ☐ no | PEDS : ☐ yes ☐ no | PEDS Pathway: | Allergies: | Temp: | Pulse: | Resp: |
|---|---|---|---|---|---|---|
| | | | | | | |

| Medications: | Birth wt: | Wt: | % | Length: | % | Head circ: | % |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Risk indicators of hearing loss:** ☐ **yes** ☐ **no**
**Hospital Newborn Hearing Screen:** ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
**Second Newborn Hearing Screen (if 2nd needed/completed):** ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

**PARENTAL CONCERNS/HISTORY:**

**NUTRITIONAL SCREEN:** [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

**DEVELOPMENTAL SCREEN:** [X] INDICATES ACCOMPLISHMENT: ☐ Some Head Control ☐ Coos, babbles ☐ Makes Eye Contact ☐ Fixes/follows with eyes ☐ Begins imitation of movement and facial expressions ☐ Tummy Time/ lifts head, neck with forearm support ☐ Startles at loud noises ☐ Other

**AGE APPROPRIATE EDUCATION AND GUIDANCE:** [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Pacifiers ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Parent reads to child ☐ Other

**BEHAVIORAL HEALTH SCREEN:** [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Social smile ☐ Enjoys interacting with others ☐ Other

**COMPREHENSIVE PHYSICAL EXAM:**

| | WNL | Abnormal (see notes below) | | WNL | Abnormal (see notes below) |
|---|---|---|---|---|---|
| Skin/Hair/Nails | | | Lungs | | |
| Eyes/Vision | | | Abdomen | | |
| Ear | | | Genitourinary | | |
| Mouth/Throat/Teeth | | | Extremities | | |
| Nose/Head/Neck | | | Spine | | |
| Heart | | | Neurological | | |

**ASSESSMENT/PLAN/FOLLOW UP**

| | |
|---|---|
| **LABS ORDERED:** | [X] INDICATES ORDERED ☐ 2nd Newborn screening **(if needed)** ☐ Other |
| **IMMUNIZATIONS:** | [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other |
| **REFERRALS:** | [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other |

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**